

## **REQUISITION FOR METASTASIS VS PRIMARY TUMOR COMPARATIVE MUTATIONAL PROFILE OF MULTIPLE TUMORS**

Include completed requisition with sample

Client Services: 844-227-7621 | labsupport@interpacediagnostics.com

For additional information, please contact Client Services

CLINICAL REPORTS	PATIENT INFORMATION (may adhere patient label)
TEST REPORTS SUBMITTED FOR THIS CASE:	DATIENT NAME
PATHOLOGY REPORT OTHER:	PATIENT NAME (Last Name, First, MI)
CYTOLOGY REPORT ————	DATE OF BIRTH SEX:  FEMALE  MALE
SUBMITTING DIAGNOSIS	STREET ADDRESS
ICD CODES (REQUIRED):	CITY STATE ZIP
Please indicate ALL applicable diagnosis codes above.	PHONE # SSN or MRN
THE DIAGNOSIS CODE(S) PROVIDED SHOULD ALWAYS BE BASED UPON WHAT CAN BE SUPPORTED WITHIN THE PATIENT'S MEDICAL RECORD.	☐ PATIENT'S DEMOGRAPHIC INFORMATION ATTACHED (FACE SHEET)
TESTING CANNOT BE DONE UNLESS ICD CODE(S) ARE INCLUDED.	BILLING INFORMATION
SPECIMEN INFORMATION	PATIENT BILLING INFORMATION ATTACHED (Face Sheet, Photocopies of Cards, etc)
SPECIMEN COLLECTION SETTING	BILL TO:
HOSPITAL (INPATIENT): Date of Discharge	☐ MEDICARE ☐ PRIVATE INSURANCE ☐ ORDERING INSTITUTION
HOSPITAL (OUTPATIENT) NON-HOSPITAL AFFILIATED SETTING	☐ MEDICAID ☐ PATIENT PRE-PAY (US check, cert. funds, etc.)
SPECIMEN 1	INSURANCE NAME
COLLECTION DATE TIME	POLICY # GROUP #
ORGAN/TISSUE	POLICY HOLDER NAME
PATHOLOGY NOS	DATE OF BIRTH
☐ HISTOLOGY SLIDES (H&E + 8 UNSTAINED)	(MM/DD/YYYY)  INTERPACE DIAGNOSTICS WILL BILL DIRECTLY FOR COVERED PATIENTS,
#STAINED #UNSTAINED	WHEREVER PERMITTED BY GOVERNMENT REGULATIONS, PAYER BILLING POLICIES, OR CONTRACTUAL ARRANGEMENTS. IF PATIENT OR INSURANCE INFORMATION IS
CYTOLOGY SLIDES (PAPANICOLAOU STAINED)	NOT COMPLETED OR ATTCHED, YOUR FACILITY WILL BE BILLED.
#SLIDES FROM: (check box)	PROVIDER INFORMATION
PARAFFIN EMBEDDED TISSUE BLOCK	ORDERING INSTITUTION:
SPECIMEN 2	
COLLECTION DATE TIME AM PM	COLLECTING INSTITUTION:
ORGAN/TISSUE	COLLECTING INSTITUTION.
PATHOLOGY NOS	ODDEDING DUVERGIANG). NDI TEL FAV
☐ HISTOLOGY SLIDES (H&E + 8 UNSTAINED)	ORDERING PHYSICIAN(S): NPI TEL FAX
#STAINED #UNSTAINED	
CYTOLOGY SLIDES (PAPANICOLAOU STAINED)	
#SLIDES FROM: (check box)	
☐ PARAFFIN EMBEDDED TISSUE BLOCK	FAV ADDIL DEDODTO TO
Use additional requisitions for additional specimens	FAX ADD'L REPORTS TO:
·	SIGNATURE
REQUIRED FOR MEDICARE PATIENTS  If this test is ordered more than 14 days after discharge, you must identify factors	Order Metastasis vs. Primary Tumor testing by signing and dating this section.  I hereby certify that the request for the above test for which reimbursement from
that affected the time of ordering the test.	Medicare, or third-party payors, will be sought is reasonable and medically necessary for the diagnosis, care, and treatment of this patient's condition. I also
REASON CODES	authorize providing this patient's test results to the patient's third-party payor. I
1. COMPLEX CASE required extensive review and deliberation	certify that the patient or referring physician has given consent to the test I have ordered.
<ul> <li>2. INCONCLUSIVE DIAGNOSIS after initial workup; molecular studies ordered for additional data</li> </ul>	PHYSICIAN SIGNATURE
3. REVIEW OF INITIAL TEST RESULTS WITH PATIENT required prior to ordering additional studies	PRINT NAME DATE SIGNED
4. CONSULTATION WITH OTHER PHYSICIAN(S) required time to schedule and obtain their input	(MM/DD/YYYY)  STAFF CONTACT
5: OTHER:	PHONE FAX
INTERPACE DIAGNOSTICS   2515 LIBERTY AVENUE   DITTSPLIES	N. P. 45000   044 007 7004   1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1